**Transcript: Public Health Research and Me**

***‘Founding Fuse – from idea to impact’***

**Host and Fuse Public Partner Victoria Bartle speaks with**

**Eugene Milne MBE**

**Victoria Bartle:** Hello, and welcome to our podcast ‘Public Health Research and Me’. This podcast is led by public partners from Fuse, the Centre for Translational Research in Public Health, and brings together the five northeast universities of Durham, Newcastle, Northumbria, Sunderland, and Teesside in a unique collaboration to deliver world class research to improve health and wellbeing and tackle inequalities. And Fuse is also a founding member of the NIHR School for Public Health Research. So my name's Victoria Bartle, and I'm a public contributor collaborating with Fuse on this podcast, and I've been involved with research from a patient and public perspective since I had to stop working in 2016 due to multiple long-term health conditions. I absolutely love being able to influence research into health and social care and I know that the input from every public partner makes to research more focused and benefiting to everybody.

So today I'm going to be talking to Eugene Milne, who's the recently retired Director of Public Health for Newcastle City Council, an Honorary Professor Emeritus at Newcastle University, and one of the founders of Fuse. So hello and welcome Eugene.

**Eugene Milne:** Good morning, thank you. Thank you for inviting me.

**Victoria Bartle:** It's a pleasure. ***So I wanted to talk today about your background and how did you start to get involved with research?***

**Eugene Milne:** My background is medical. I originally come from Hull and trained in medicine in Newcastle and I started doing research when I was at medical school. In the way the course was structured in those days you could do a research degree halfway through, so I did a degree in my third year at Newcastle in the metabolism of babies having heart surgery with deep hypothermic circulatory arrest. It's terrifyingly high tech but I'd always been interested in research and kind of thought I'd end up doing some of that high tech stuff. And then through the course of my career, I've kind of drifted further and further from that so completely the other end of the scale by ending up with public health and broader social research. So it had always been an interest, and it sort of developed over time.

**Victoria Bartle: *So how did you get involved with Fuse when it was getting set up, and kind of what were your goals for it when it first started?***

**Eugene Milne:** Well by that time I was a Deputy Medical Director at Northumberland Tyne and Wear Strategic Health Authority and I’d been working with the (Newcastle) University over the years. I had an honorary lectureship and worked with them, although I've never had a formal academic post, I've always worked on the service side but was very keen about trying to bring the two sides together, and when the opportunity arose to develop Centres of Excellence it seemed a really ideal time to bring together the public health expertise in the region, and look to move it closer to what we were trying to do more broadly in public health implementation. So at the outset, when the invitation to apply for (UKCRC) Centres of Excellence came out, my colleague Stephen Singleton, who was the Director at the time, and I, pushed really quite hard to bring together different parts of the region, and found a real ally in Martin White, who was leading on the Newcastle University side to do that. So we ended up really pushing for a for a single bid across the universities, I think, with a certain amount of scepticism from some of the established academics in the in the medical school. They were very wary about the idea that we could pull this together, so it was a bit of a triumph when it when it came off.

**Victoria Bartle:** ***Was that because they're so used to working individually, or because it was just something new, or do you have any idea what their barriers were?***

**Eugene Milne:** It's difficult to say. I think it's easy to get very introspective in a big institution like a university, and think you know specifically about the interest of the university or the interests of the researchers and not to think: how do we address the broader issues that are affecting the communities who actually support us and who helped establish those universities and who they should be serving.

So, I think there are all kinds of different motivations, but a big part of it was the fear that it wouldn't happen, that a consequence of bringing together different organisations might actually be a discouragement to the funding organisations. So that they might say: well, you know, we like the idea, but we don't think you can actually manage to do it and there was a certain wariness about that on the part of the funders at the outset. So we had checkpoints to see whether or not things were progressing in the way that we intended them to, which was successful.

**Victoria Bartle:** Well it’s been going for a long time now so it’s obviously working.

**Eugene Milne:** I'm hugely thrilled actually. When we had the ten-year celebration, I think until that point I didn't realise quite how much research funding had been brought in through Fuse. So, tremendously satisfying.

**Victoria Bartle:** Wow, that's fantastic. ***You've kind of already answered this but in terms of the public health strategy for the northeast. How does Fuse sit in with this, and what are the challenges for it?***

**Eugene Milne:** Well, at the time this was being developed, we were also looking at the development of a regional health and wellbeing strategy, which was published in 2007, called ‘Better Health, Fairer Health’, and was launched at that at that time by Nick Brown, who was then minister for the region, when they had ministers for the regions. And in a way what it was in that strategy, which we developed collaboratively across the region, was a precursor to what changed in the structure of public health in 2013, because you know what we put up right up at the front of it were things like the economy, environment and broader wellbeing. And things that were in the in the power of local government and communities, rather than things that were within the ambit of the NHS and clinical care. And of course have very limited leverage to be able to make change within those areas, and I think things have developed from there. Fuse was part of that, because what we were trying to do, is say well we need to be able to bring together objective evidence of what works in those environments that isn't high tech, it isn't the interest of people who are in clinical practice, necessarily. It's going to be these things that are likely to have a bigger impact on the on the broader community. So we were very interested in things like transport and winter warmth. I think, at the time we were talking about winter warmth being critical, I had no idea we would get to the point we are at now, where it's becoming absolutely pivotal to people's wellbeing, because of the cost. So it was part of a trend that I think we were trying to pursue more broadly.

**Victoria Bartle:** So you were like the first, leading the way into things that are massively important today. ***So you were a bit innovative and fortune-teller-y about the future?***

**Eugene Milne:** I wouldn't claim any kind of monopoly on that kind of vision. I think it was something that was shared more broadly. One of the things that we might come back to at some point in talking, is this thing about what’s the role of individuals in all of this. And the truth is that it's sort of a mistake to think of individuals as being… they're not individual achievements. Anything that happens that's really successful is a consequence of all kinds of different things coming together, and of collective effort, and of the way that they were implemented. There are lots of good ideas out there, not very many of them get through to implementation and have the right people in the right place to implement. And it's never one individual who does that in public health, it has to be a collaboration much more broadly.

So I don't think that we were unique. But I think that some of the implementation we managed to put in place, really worked well. And we’ve seen that happen, over my career I've seen that happen in a number of areas, it happened with Fuse, it happened with Fresh and Balance in relation to tobacco and alcohol control.

**Victoria Bartle:** ***You had some amazing successes with the Fresh Programme (the UK's first dedicated regional tobacco control programme)******didn't you?***

**Eugene Milne:** Yeah, again I’m very proud of that. But you know, the credit goes to an awful lot of people who made it happen. The idea for Fresh actually came about by accident. This was in the early 2000’s and at that time we were looking at what would have the biggest impact on health over the coming few years, at a time when the European Union had asked for bids for funding. And by coincidence, one of the Directors of the Strategic Health Authority had said to me: what have you got that we might bid to the European Union for? And I said, let's establish an Office for Tobacco Control, like the one in California and rip off everything they've done, because it clearly works.

**Victoria Bartle:** But that’s the best way to do it!

**Eugene Milne:** Absolutely right. It works there. One of the things that was critical about that, was that we don't really know which bits are the most important. So let's just try and do all the things they did, since collectively it worked. And some of the time in Public Health you have to have that kind of fuzzy edged approach and say, we're not quite sure which of the bits that work. And of course, research then feeds into thinking about how that then breaks down better, how you can improve from that. But I spent a month writing that proposal as it was enormous, and then it failed.

**Victoria Bartle:** Oh, no!

**Eugene Milne:** But no, this is the thing. Actually it was a really great failure, because – I talked about this at a Fuse conference a while ago, about things that have gone wrong that that are still worthwhile – because we built the consensus on what needed doing at that point. So we ended up doing quite a lot of it, but on a shoestring, having established that principle and it worked, and I think it's worked extremely well. But a huge amount of that credit goes to Ailsa Rutter (Director of Fresh) and Fiona Dunlop (acting Director of Fresh), who were the original - Ailsa who has stuck with it over the years. All the people who worked through that, and the support across the region that it's had, because there was that really broad buy-in. So it's good to be a part of it. But I think nobody should claim sole authorship for that sort of thing.

**Victoria Bartle:** Well that kind of leads me onto the next one. ***So you seem so committed to co-production and collaborative working. So what do you see as the positives, negatives and barriers towards that?***

**Eugene Milne:** I think co-production is fantastic for ownership. You want people to have that sense of shared ownership. And I think there's also a phenomenon that you see, certainly with healthcare delivery, that organisations and groups who are research engaged, actually get better at pretty well everything else as well. I think it's to do with the kind of critical mindset, and the way that people think about what they're doing, their tendency to question things and challenge. But it moves standards up more generally, and I think that co-production is a way of thinking about that, too.

I think there are disadvantages as well. The thing that I probably worry about most often is the tendency of people to say, well let's do the research to prove the thing that we already know. Which is not really the way to do it. I think you need to have a degree of what the researchers call equipoise. To say, well we don't really know whether this works or not, so let's do the work, and then find out. And of course, after that the big challenge becomes, what do you do either if it works, or if it doesn't work? If you're pretty clear about either one, are you actually going to stop it? And that becomes an incredibly difficult task. It's amazed me how many times we've looked at something and said we should stop doing this because it doesn't work, and people have said well what are you going to do in its place? You kind of think well, but it’s not working, so you know it would be great to do something that does work, but you don't just do something else because you're replacing something that doesn't.

**Victoria Bartle:** ***Is that kind of the bureaucracy of local government? Is that where, red tape and trying to turn around a runaway train, kind of mentality comes in?***

**Eugene Milne:** It's partly that. But it's also partly a desire to be seen to be doing something for people in need, which I completely understand. But I think a real difficulty, then, is that doing a thing, because something should be done, can become a substitute for doing something that works, or for saying actually, this isn't doing them any good and we need to really rethink this. And because the other side of that is, you find something that does work, and even when it works, then trying to get it funded can be an absolute nightmare too. There are lots of advantages to it, and of course you've generated a lot more advocates once you've done that. And looking to bring about change in public health, having that breadth of advocacy is incredibly important. I think people tend to think that change will happen because you change a law, you change a rule or regulation – it doesn't really. Public consent for the change, tends to be the thing that you really need, because once you've got public consent for it, then it's likely to take place. We saw that with things, famously with things like seat belt laws, and so on. And actually, we saw it with smoking legislation. When we started off on the path towards the legislation on smoking, that eventually came in 2007, at the outset people kind of said: it will never happen here, and there wasn't support. And I remember Martin White and some of the medical students did some surveying on Northumberland Street, and there was only, as I recall, thirty-five percent support for a ban on smoking in pubs and working men's clubs. And by the time the legislation was passed it was above sixty-five percent in the region. So things swung a long way, and a huge part of that, I think, was that big drive that we supported, it wasn’t exclusively this, but in order to try and change people's views along the way, there were more responses to the consultation on smoking from the North East, than anywhere else in the country. And that was driven through what we were doing with Fresh.

**Victoria Bartle:** Wow that’s amazing. I can kind of see how the attitude towards smoking has changed over my lifetime. When I was younger everybody smoked, my parents both smoked. And myself, and my sister were always like, you shouldn’t smoke it's bad for your health, because that's what we were brought up, being told in the eighties and nineties. It’s bad for you. You shouldn't smoke. It's really bad for you, and nowadays it's really unusual to see people smoking. I find it really quite jarring, because I'm not used to it at all, and it feels like It's become embedded in society. It's just part of the culture that smoking is bad for you, and you shouldn't really do it, and not very many people do.

**Eugene Milne:** Yeah, I think I agree. I remember I went travelling on buses when I was growing up in Hull and the East Riding of Yorkshire and the upstairs used to be the deck where people went and smoked, and there used to be a layer of tar on the ceiling. Kids used to write their names in, it’s gross.

**Victoria Bartle:** But you can see the impact of what public health can achieve. It's absolutely amazing. ***So in terms of public involvement then, how do you see that fitting in with collaborative working for public health and research?***

**Eugene Milne:** So I think it's a really interesting question, because Councils have mechanisms for public engagement, and there's a big question about whether they’re fit for purpose. I think that in some instances - this is a very broad answer by the way - I think in some instances they're better than the things that are used by researchers. I’m bothered when I read research applications and bids that say, you know, we had a couple of public meetings, we had a focus group. And what will you do with the findings? Well we'll publish them and go to a conference. And I think you're not really there are you?

**Victoria Bartle:** It's like paying lip service to public involvement, rather than actually doing it properly.

**Eugene Milne:** I don't think I’m expert in it, I have to say. I think there are others who would be much better placed to answer a question like that. But I think it's a crucial part of what we're trying to do, both in terms of aiding understanding of why things might be done in a particular way, and what might happen, but also, as I have repeatedly said, in terms of allowing people to own those outcomes and understand why they matter, and whether or not, something is going to change. Not a service necessarily, but if something is going to change, why it might change and what the thinking is behind that change. And it's not always easy. One of the most difficult meetings I was ever involved in was when we put drug recovery into Fenham Library (Newcastle). And we had some fairly hostile public meetings in there. I think it's worked really well. I think it was worth having those meetings and facing down the discussion, the opposition. We did have people who came back subsequently and said we opposed it, and we were wrong. It's fine. It was always a very safe, very supervised thing. I think getting to the point where people understood that it was actually about the viability of the library as well as the service that we wanted to provide in a community that was the community of people who were in those programmes - difficult. So it's a rocky road, I think, but at the end of it it’s worth pursuing, because I don't think you get any public change without consent. I think you need to have the consent of the public, and that could be at a local level as well as a national level.

**Victoria Bartle:** But it's about understanding as well, from the public perspective. If you just go in and do something, like put in recovery services into Fenham Library, then, of course, people are going to be unsure, because they don't know the whole context of what's going to be actually happening. But if you do some engagement and communicate the processes, and how it's going to work, and what it's actually going to look like, then you're educating people and you're informing them. And you're keeping them included in what's happening in the local community, and that's going to be beneficial long term, because yes, they might oppose it, and they might come up with questions that you'd never thought of, and then you can address those and make changes. But also, it's about the local government being able to communicate the logic and the thinking behind things that they're implementing before people just get terrified and have that knee-jerk reaction to it.

**Eugene Milne:** I'm pretty sure we could have done it better, the communication better than we did, and I think, but having said that, I think we got there in the end, and we learned lessons along the way in doing it. And I think that's the best you can hope for really is that you develop with the public that you're trying to serve, and you know, find ways to have that communication.

**Victoria Bartle:** Yeah. And if you don't do it at all, then you never learn, and you'll never make improvements, and it'll constantly be adversarial. So you have to start somewhere and yes, if you make mistakes, the whole point is that you learn from them.

***In terms of the implementation then, what would you like to see improve for being able to implement the things that work, like you said, rather than having to still run with the things that are just already in place. If you had a magic wand, what would you do?***

**Eugene Milne:** Well, I mean there, there's no escaping the fact that a lot of stuff costs money, and you know, and an awful lot of the things that need changing in public health are so fundamental that they're not about investment in services. They're about giving people financial support, and you know, getting them out of fuel and food poverty and all the rest. So you know, if I had a magic wand, I think I'd probably be starting there, and we're in this terrible position that you kind of think you wouldn't want to start them now, we should have started on things some time ago. We should have been investing in education and infrastructure through the last decade, which hasn’t happened because of austerity. And now we're in a very difficult position, where things - having been made a lot worse recently - mean that, you know, we are going to see further cuts in public spending. So I think money is a is a huge thing.

I would love to get a better understanding amongst politicians, for sure, the general public, but also amongst colleagues in the NHS of how prevention works, what we already know about it, and where the emphasis ought to be? This goes all the way to the top. I was listening to the radio recently and Sir John Bell, from (University of) Oxford, was talking about Our Future Health, and in the course of that interview he talked about progress that had been made on prevention in heart disease, and a couple of things that he said in that, one of them was that he said: over the last decade, we've come to realise that you have to prevent things further upstream. And I was thinking, we've known that for a very great deal longer than the last decade actually, and we've been doing it for longer than that. And he also said: and then over the last twenty years or so, he talked about the huge fall in heart disease deaths – and it is huge – it’s a massive drop from where we were 20 years ago. And talked about two elements of that being blood pressure treatments and statins. Well, they both work, they both matter. But actually, they're only responsible for a really quite small portion of the overall fall, between them, you know, if you look at some of the work Simon Capewell and his colleagues have done around attribution of change in cardiac mortality risk over time, I think that they amount to about 20 percent of the overall contribution. The change in smoking accounts for about half of the change in England over that time. And you kind of think, how is it that you're talking about this, and not saying, here are the things that have made the difference. Here are the things that have made a really big difference. So I was disappointed in that, and I think there is this tendency still to, particularly you know, it's very strong amongst medical colleagues to think well, we need to do this by earlier diagnosis and treatment. And there's a role for that but actually we're also talking about stuff that's much further upstream, and which is not sexy, it's not medically high tech, it's not the stuff I started out researching, it's where I ended up, you know, but can have a really big influence and I'm disappointed that's not more broadly understood. And in relation to that, some of the things that we're interested in on the Public Health side, like you know, health economics, value for money, what it is we should be spending. Those things are not well understood in medical circles, to be honest. I used to work at NICE (National Institute for Health and Care Excellence) as well. I was on the Technology Appraisal Committee for over ten years and sometime during that one of my colleagues from Newcastle Hospitals, a professor of haematology joined the committee and we used to travel down to Manchester and back on the same train. So I remember talking to him on the train about what was going on at NICE and he's saying, this stuff is really, really important. Why are we not taught health economics at medical school? Why? And he became so enthused by it, I think he's now the chair of one of the committees there because the bug bit, and it is terrifically important to understand those relative values, and I'd love to see that that kind of thinking extended more broadly to say, okay, well, what actually is the relative value of investment in greenspace and parks, in comparison to what we might spend it on a health technology. Because I think we would find that those are much better investments in many cases.

**Victoria Bartle:** Right. ***So do you think that's an issue with research dissemination, or just the mentality of the academics and clinicians to kind of ‘stay in their lane’?***

**Eugene Milne:** I think it's a cultural thing. I think that we haven't managed to get the message out properly. Using NICE as a kind of an illustration of that.

**Victoria Bartle:** Can we just explain what NICE is, if there’s any listeners who don’t know.

**Eugene Milne:** Originally it was the National Institute of Clinical Excellence. It's now technically the National Institute of Health and Care Excellence, but it's still known as NICE, and it is responsible for determining whether or not largely drugs, but also devices and methods of treatment should be incorporated into the NHS. So most famously, it's the high-cost drugs that NICE looks at to decide whether or not they should be available.

They had a conference a few years ago in Manchester, and one of the speakers was a guy from the BBC. He’d made a programme about the process of a drug through the committees, and he came to give a talk to all the people who were the committee members and what stuck with me from it because he said: “I came to this, not really knowing anything about what NICE does.” He said, “I want to tell you, what it does is fantastic. I think you do brilliant work, it's incredibly important. You are terrible at informing people about what you are doing!” And, I think he's right, I think it's just not well communicated. To be fair, I don't think it's always easy to understand, and one of the curses of public health is that it has the appearance of being easy to understand, but then, actually, there are things underneath that, that are counterintuitive, and it's so easy to miss those. But it struck me that we still have a big communication problem. Stop me if I'm rambling on too much on this.

**Victoria Bartle:** No, it's really interesting.

**Eugene Milne:** We can end up being our own worst enemies, by wearing our political colours a little too obviously on our sleeve. In terms of where we can go with public health strategy, what we can achieve. We have to be able to work with whatever government is in power. We could turn around and say, well we don't like the government, what it's doing is wrong. They’ll say fine, thank you, you want to be a politician? Well there's a ballot box. Go and join in. Whereas really we have to say, okay, we might feel that.

**Victoria Bartle:** But those are the cards that you're dealt. You've got to still help people at the end of the day. You've got to work around the systems that are in place? ***Is that kind of what you are saying?***

**Eugene Milne:** Absolutely right. And I think some of the time we manage to alienate politicians in a way that really doesn't help us. Now, recently they've alienated themselves from an awful lot of people. But I think that there are people on all sides who we can work with. And I think we need to have that level of trust, that says, okay we might disagree with you politically, but we're going to try and do the best for people, because I think actually, frankly, even in the face of that most people who go into politics, go into politics because they want to do good.

**Victoria Bartle:** I think that that's probably exactly what I would have said. Not having any of your knowledge or understanding of the systems and things. We do just need to kind of put issues aside and work together to make life better for everybody.

So thinking about the financial challenges and the current economic issues that we've got. ***Do you think that we'll see any new public health initiatives being implemented in the next few years, or do you think we're going to have to run with what we've got?*** I mean, you mentioned Our Future Health projects - ***where do you see public health going in the next like five to ten years?***

**Eugene Milne:** Well, I don't think Our Future Health is the right way forward. I'd be very interested to see what comes out of the work they’re doing. But I think a bigger study looking at upstream causes is... This is my prediction around that, I don't think they're going to find huge amounts that allow them really to make a difference to the broader public health. I think they may find things that will make differences to small groups of individuals. We could talk about that at much greater length, but I won't – I’d be happy to another time if people are interested, but I think that experience suggests that that's not so likely to happen. I think that funding is going to be a big issue for us. I think part of the message we do need to carry on getting over is: if you really want to save money from a system, then that has to come out of improving the general health of the population. It's not going to come out of treating people once they're sick, it's not. So I think there is the scope there still to have that debate. And there are always some interventions that can be done without additional funding or with adjustment of what we're doing now, I think the ‘low hanging fruit’ is all gone in those areas. I think people have been picking it for far too long, so it's going to be, it's become progressively more difficult. So I think there'll be initiatives. I don't think they'll necessarily be the ones that that we might have hoped for. I hope that we'll see some national sense around things like tobacco policy and obesity, and so on. There is the potential for any kind of green economic development, also to have big spin offs in terms of wellbeing and health for the general population. So I think there are some possibilities, but it’s hard to see how we're going to have a real boom given the current economic situation. And I think a lot of the focus for people in public health is going to be on, you know: how do you ameliorate the impacts of huge disadvantage, rather than being able to really tackle the fundamental causes of that disadvantage?

**Victoria Bartle:** Wow, my head is overflowing with stuff now! No, it's so interesting, and it's such a massive challenge, and it's obviously something that we need to do things about. Because, like you said, prevention is cheaper than a cure. It makes much more sense in terms of health, wellbeing, finances, everything, to try and keep people healthy in the first place. And when you're looking at social deprivation and food poverty and fuel poverty and everything. We've just got so many barriers towards that, that it's a huge, big, cultural, societal issue. ***Where do you start?***

**Eugene Milne:** Yes, I don't envy the inheritors of the… well you know, Jeremy Hunt's position is a difficult one at the moment, and I think that it would be difficult for anybody who's in that post. I’m just hoping that he's going to make the right decisions.

**Victoria Bartle:** Yeah, well fingers crossed.

***So, looking back – we'll move away from the depressing side of it – looking back, what was your proudest moment as Director of Public Health?***

**Eugene Milne:** You told me you were going to ask me this question, and it’s really hard to think about. On a personal level, I was awarded the Alwyn Smith Prize by the Faculty of Public Health this year (2022), which is a kind of lifetime achievement thing, and that was really, really nice. But I go back to what I was saying before, proudest achievements are really kind of team things. I'm very proud of some of my trainees, and the team, and what they've done. I was really proud to be a part of the Council team through Covid. I think that the team there and, in fact – more broadly across Newcastle – the collaboration between organisations was, I think, outstanding in the face of really difficult circumstances. If it sounds like at times where we've been talking, I've been a bit critical of the NHS, I think the NHS in Newcastle was amazing. I think across the region was amazing. Proud seems an odd thing to say about a role in Covid, which I wish hadn't happened, and I wish we'd been better prepared nationally in advance of that. There are things that clearly one would change about the way that the whole the whole thing ran. But it was a remarkable experience, and I worked with some terrific people.

**Victoria Bartle:** Yeah, that just sounds amazing. I can't possibly imagine what you all went through, trying to organise things in the midst of the national mess, that was the response to Covid. How on earth do you draw any kind of semblance of order and structure out of the national guidelines that we were being given?

**Eugene Milne:** At times it was difficult, I think there were lots of people having a very, very, very much worse time than I was having, frankly, through the whole of this, and I am always aware of that. But I think people stepping up and doing their thing, whether it’s their original role you know - binmen were heroic.

**Victoria Bartle:** Yeah, absolutely amazing.

**Eugene Milne:** They were brilliant. Or people stepping out of their roles to do other things. Again, you know, librarians getting involved with the vaccine deliveries. Yeah, that sort of thing, I think, was just marvellous. There was a lot of, you know, really great, humane contribution from a lot of people.

**Victoria Bartle:** Yeah, that was absolutely phenomenal, like seeing people pull together, and how much everybody cared for their neighbours, and were willing to do just anything to kind of help out and be involved and be useful and positive. I think that made me very happy to be part of society, during the whole thing.

**Eugene Milne:** But talking about challenges, I think the long-term challenge of that, both in terms of people's physical health, and you can see that there are consequences there. We do know that excess mortality is still high subsequent to the pandemic. But I think, the thing that probably worries me most in terms of the legacy of Covid at the moment, is the impact on education and young people's development. And I don't think we've really fathomed that yet. I think there's a huge scar on the development of young people in the country because of that. Yeah, that needs to be addressed. That should be a big priority in future thinking.

**Victoria Bartle:** I know quite a few teachers. And yeah, some of the stories I've heard about kids trying to sit their SATs (key stage 2 national curriculum tests) when they've had like two years of no education. And it's absolutely terrifying with the kind of limitations that we're putting on that generation of children because of what they had to experience and go through. And then a lot of that links to poverty and digital poverty and like issues like if your parents were working from home, or were key workers, how on earth are they meant to try and teach the kids at the same time. It was a huge, big challenge for parents and children. I think that yeah, I totally agree with you that that's going to be a huge barrier for society moving forward. So that was cheery!

**Eugene Milne:** Sorry about that!

**Victoria Bartle:** No, it's absolutely fine!

**Eugene Milne:** There was a lot of good stuff in there as well!

**Victoria Bartle:** I've got a couple more questions for you.

***In terms of what messages you'd want to give to central government, thinking about the successes that you've had in the North East, and what kind of learnings you've had from public health, from implementing research and disseminating results and things. What would you want to tell Jeremy Hunt to do?***

**Eugene Milne:** Well, I think the thing I was saying before, that we should be able to work together without a political slant. Actually, I did always find that at the Council, that on public health issues, the party politics didn't really get in the way. I don't know it's true everywhere. I don't think it is, but I found that the opposition were as interested in public health issues and wanted to work. And I think we can do that. I think that's important. A key message in the light of what's happened over recent months to get away from this ludicrous, false dichotomy of nannying state, and people's wellbeing. It's not like that, you know. Let’s have sensible conversations about what's in the best interest of supporting people and what helps people to shape their decisions. It's not about forcing people to live in a particular way, but about creating environments in which they actually have genuine choices. Rather than this idea that somehow people have chosen to be fat or cold. It doesn't work like that, you know. I think we can get through that. And you see it, I've seen it, with national politicians as well, who have grasped what we're getting at and why it shouldn't be put into that kind of polarised context. So get rid of the 55 Tufton Street nonsense and let's have some good conversations about how best we help people.

**Victoria Bartle:** I totally agree with you.

**Eugene Milne:** These things sort of come back to bite you, because a few years later, somebody comes back with a study and says: you need to change these things. You’re thinking, we planted that seed about three years ago, knowing it was going to flower sometime around about now. So I think it becomes part of that kind of spreading of understanding and advocacy for change.

**Victoria Bartle:** Yeah, and like long-term planning and yeah kind of trying to see where the issues lie, and then fitting the research in to find out what's the best way to kind of approach it.

***And if you had one message for our listeners to take away. What would it be?***

**Eugene Milne:** Again, you told me you were going ask me this. It sounds a little pompous, but there’s a Martin Luther King quote, a really famous one that: “the arc of the moral universe is long, but it bends towards justice”. And I think actually it’s really worth bearing that in mind, that even with the setbacks that we've seen - public health is a very long game - we've got concerns that need to be addressed now and in the next few years, but actually we're thinking over decades and lifetimes. And, we need to have that perspective, and think, okay things have been really rocky for the last few years, but there will be times when things will get better, and if we keep pushing we can still see progress in the face of that.

**Victoria Bartle:** That's amazing. Yeah, that's lovely.

Okay. So if you’re a fan of our ‘Public Health Research and Me’ podcast, please subscribe on your preferred streaming platform. Let us know how we're doing with a rating or review, and share with your friends, family, colleagues and networks.

And I just want to finish by saying, thank you so much Eugene. It's been so interesting talking to you - I could go on for the rest of the day, really!

**Eugene Milne:** Thank you. It's been a pleasure.